

William Fuller
September 24, 2018

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UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH DAKOTA
SOUTHERN DIVISION

* * * * *
SALA NAAMBWE and YVETTE NIMENYA,
Plaintiff, Case: 4:17-cv-04123-LLP
vs.
Avera Medical Group
SMITHFIELD FOODS, INC., Sioux Falls, SD
September 24, 2018
Defendant. 4:35 p.m.
* * * * *

D E P O S I T I O N O F

DR. WILLIAM C. FULLER

* * * * *

APPEARANCES

Ms. Stephanie Pochop, Esq.
Johnson, Pochop & Bartling
PO Box 149
Gregory, South Dakota

for the Plaintiffs

Ms. Andrea R. Calem
Hunton Andrews Kurth LLP
2200 Pennsylvania Avenue, NW
Washington, D.C. 20037

and

Ms. Lisa Hansen Marso
Boyce Law Firm
Sioux Falls, South Dakota

for the Defendant

Also present: Sala Naambwe
Mark Cimeley

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S T I P U L A T I O N

It is hereby stipulated and agreed, by and between the above-named parties through their attorneys of record, whose appearances have been hereinabove noted, that the deposition of DR. WILLIAM C. FULLER may be taken at this time and place, that is, at Avera Medical Group Behavioral Health Center, Sioux Falls, South Dakota, on the 24th of September, 2018, commencing at the hour of 4:35 p.m.; said deposition taken before Suzanne Brudigan, RPR, CSR, a Notary Public within and for the State of South Dakota; said deposition taken for the purpose of discovery or for use at trial or for each of said purposes, and said deposition is taken in accordance with the applicable Rules of Civil Procedure as if taken pursuant to written notice. Objections, except as to the form of the question, are reserved until the time of trial. (Fuller Deposition Exs. 1, 2, 4, 5 marked.)

DR. WILLIAM C. FULLER,

called as a witness, being first duly sworn, testified as follows:

EXAMINATION BY MS. CALEM:

Q. Good afternoon, Dr. Fuller.

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INDEX OF EXAMINATIONS

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* * * * *

INDEX OF DEPOSITION EXHIBITS

Marked

Exhibit 1 -- 3
Subpoena for Dr. Fuller

Exhibit 2 -- 3
LSS Clinic AMB Report
(Pages 22-26)

Exhibit 3 -- 12
LSS Clinic AMB Report
(Pages 11-16)

Exhibit 4 -- 3
(Was not used)

Exhibit 5 -- 3
LSS Clinic AMB Report
(Pages 5-10)

Exhibit 6 -- 12
Curriculum Vitae and
other records produced
by Dr. Fuller
(62 pages)

* * *
Original Exhibits 1-6 were returned to Ms. Calem
via USPS. The original transcript of this
deposition was emailed to Ms. Calem.
* * *

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A. Hello.

Q. My name is Andrea Calem and I am an attorney for Smithfield Company Corporation and I represent Smithfield in connection with a lawsuit filed by one of your patients, Sala Naambwe. We are here to take your deposition, and I assure you, I will be as rapid as possible. I know it's late in the day.

Do you have an understanding of what this case is about?

A. No.

Q. Okay. All right. Can you just state your full name for the record, please.

A. William Fuller.

Q. What's your occupation?

A. Physician, psychiatrist.

Q. Where do you work?

A. Avera Behavioral Health and University of South Dakota Sanford School of Medicine --

Q. Okay.

A. -- and I have some consulting locations that I go to, but.

Q. Did you know that you've been identified as a witness in this case?

A. I was subpoenaed.

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1 Q. For this --
2 A. For this deposition, I assume that.
3 Q. Did you know that you had been identified as a
4 trial witness in this case?
5 A. No.
6 Q. Have you ever been asked to give any expert
7 opinions in this case?
8 A. No.
9 Q. Have you been asked to formulate any opinions
10 relating to Miss Naambwe in this case?
11 A. For purposes of what we're doing here today, no.
12 Q. All right. Have you been deposed before?
13 A. Yes.
14 Q. How many times, roughly?
15 A. I don't know. I don't know. Maybe 15. I don't
16 know.
17 Q. And were any of these depositions in connection
18 with testifying as an expert?
19 A. Yeah, a few of them were.
20 Q. What courts were those in, do you know, do you
21 remember?
22 A. No, I don't really.
23 Q. Okay. And the rest of the times that you were
24 deposed, you were deposed as a treating
25 physician?

7

1 Q. Okay. How long was the residency?
2 A. Three years.
3 Q. And can you briefly describe your employment
4 after you completed your residency.
5 A. So at the completion of residency, I came to
6 South Dakota full-time, employee of the State of
7 South Dakota, and worked with University
8 Physicians which was a practice corporation of
9 the university -- or the medical school until
10 2002, which time I became a full-time employee of
11 Avera and contracted with the State of
12 South Dakota, so.
13 Q. So 2002 you became a full-time employee of Avera?
14 A. Correct.
15 Q. Is your practice Avera Medical Group University
16 Psychiatry?
17 A. Yes.
18 Q. Is that a separate business entity within Avera?
19 A. No, I don't believe so.
20 Q. Is it associated with any university?
21 A. University of South Dakota Sanford School of
22 Medicine.
23 Q. Okay. And do you work at Avera full-time?
24 A. Well, yeah, I'm a full-time employee, correct,
25 but I do some consulting so I'm not actually here

6

1 A. Correct.
2 Q. All right. Have you -- I take it you have not
3 written any report relating to Miss Naambwe that
4 is -- that you know is going to be used in the
5 litigation?
6 A. Correct.
7 Q. And what states are you licensed to practice
8 medicine?
9 A. South Dakota, Iowa, Minnesota, Nebraska.
10 Q. And you're duly licensed in each of those
11 jurisdictions?
12 A. Correct.
13 Q. Licenses are current and on file at the
14 appropriate places?
15 A. Yes. Yes.
16 Q. Within your practice of psychiatry, do you have a
17 specialty?
18 A. No.
19 Q. Can you briefly describe your educational
20 background for me?
21 A. Went to undergraduate University of Nebraska
22 Medical School, University of Nebraska psychiatry
23 residency at Nebraska Psychiatric Association
24 which is affiliated with the University of
25 Nebraska and that would be it.

8

1 probably about a third of the time, I guess,
2 yeah.
3 Q. All right. And where is the consulting that you
4 do?
5 A. At Bethesda Counseling which is in Sioux Falls
6 and Orange City, Iowa, and Southwestern Mental
7 Health Center which is in Luverne, Pipestone,
8 Worthington, so.
9 Q. Approximately how many hours a week are you at
10 the medical -- the University Psychiatry Group
11 here?
12 A. Probably about, I'd say, ten hours a week.
13 Q. What's your current patient load here?
14 A. Patients I see independently of the residents is
15 probably, like, 25 patients is all. The rest of
16 them I see with psychiatry residents.
17 Q. Do you have a private practice separate and apart
18 from any of these other entities, Avera and your
19 consulting jobs?
20 A. No.
21 Q. So you see approximately 25 patients independent
22 of residents. Is that for medication management?
23 A. That and psychotherapy, yeah.
24 Q. So you do both?
25 A. Yes.

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1 Q. And are you ever asked to see a patient purely
2 for diagnostic purposes, forensic purposes, for
3 litigation?
4 A. Not for a long time.
5 Q. And do you have privileges -- Obviously you have
6 privileges at the hospital associated with Avera.
7 A. Uh-huh.
8 Q. Any other local hospitals?
9 A. Sanford and Avera in Mitchell and Yankton and
10 couple hospitals in Minnesota.
11 Q. These are all -- Okay. That's a lot of
12 hospitals.
13 A. There you go.
14 Q. So they are not only in South Dakota but the
15 other jurisdictions in which you're licensed?
16 A. Well, I don't have any privileges in any Iowa
17 hospitals that -- Well, take that back. I'm not
18 sure about that.
19 Q. Okay.
20 A. I did have affiliation with a hospital down by
21 Orange City, but I think I maybe dropped off of
22 that one.
23 Q. Do you have any questions about the deposition
24 process? You've been deposed many times before,
25 but is there anything about the process or the

11

1 Q. You were asked to bring documents to the
2 deposition. Avera has previously produced to us
3 what I believe to be are the complete records of
4 her treatment at University Psychiatry. I'm
5 showing that the last date of treatment, the last
6 report is in April of 2018. Is there anything
7 after that?
8 A. Yeah, I believe so.
9 Q. Are those the records that you brought with you
10 today pursuant to the subpoena?
11 A. Yeah.
12 Q. Okay.
13 A. They're probably duplicates of mostly, maybe not
14 the last note. 9-13-2018.
15 MS. CALEM: May we go off the record for a
16 minute so I have an opportunity to look through
17 these records.
18 (An off-the-record discussion was held.)
19 MS. CALEM: Let's go back on the record.
20 I would like to take all of the documents
21 that Dr. Fuller has produced here today and as a
22 group we'll make them Exhibit 6, including the
23 CV.
24 MS. POCHOP: Can I get a copy?
25 MS. MARSO: Right now or with the

10

1 case that you want to ask me before we go
2 further?
3 A. Not really, no.
4 Q. You're here today because you were served with a
5 subpoena, correct?
6 A. Correct.
7 Q. I'm handing you what's been marked as Exhibit 1
8 to your deposition. Can you take a look at that
9 and tell me if that is the subpoena with which
10 you were served?
11 A. I believe so, yep.
12 Q. And is -- There's a page at the end, I believe,
13 which has your signature on it acknowledging
14 receipt of the subpoena?
15 A. Correct.
16 Q. And that's your signature?
17 A. It is.
18 Q. All right. As you sit here today, do you have an
19 independent recollection of treating Sala
20 Naambwe?
21 A. Probably not, that's not assisted by, you know,
22 reading the records.
23 Q. Before you came here today, did you read
24 Miss Naambwe's records?
25 A. Yes.

12

1 transcript?
2 MARK CIMELEY: I can get you a copy.
3 MS. POCHOP: Can I have a copy during this?
4 (Fuller Deposition Exhibit 6 marked.)
5 MS. CALEM: So, yeah, we're going to need a
6 copy of this file. I'm going to put that in
7 front of you but just keep it all together.
8 MS. POCHOP: Can we send it with him to get
9 a copy while we're doing this?
10 MS. CALEM: Would you mind?
11 MR. CIMELEY: No.
12 BY MS. CALEM:
13 Q. There are several -- I have reports that were
14 produced showing several visits by Miss Naambwe
15 to your practice and you have produced one more.
16 So I'm going to show you what I believe to be the
17 four reports that I have -- And we don't have the
18 page from that?
19 MS. MARSO: We're waiting for a couple
20 pages.
21 MS. CALEM: We're waiting for it, I'm sorry,
22 Doctor. I'll just use my copy so that would be
23 Exhibit 3.
24 (Fuller Deposition Exhibit 3 marked.)
25 Q. All right. So these four reports, if you could

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1 take a look at them. Those are the reports I
2 have. I just want to run through them briefly.
3 The first one that I have, it has the Bates
4 numbers in the bottom right-hand corner of the
5 pages 22 to 26. Do you see down at the bottom
6 right-hand corner? Is that numbered 22 through
7 26?

8 A. Yes.

9 Q. Okay. This appears to be a visit that
10 Miss Naambwe had to this practice. Can you tell
11 meet the date of service, the date of the visit?

12 A. 5-9-2018.

13 Q. And she saw --

14 A. Correction. 5-9-2017.

15 Q. Okay. And at that time she saw Dr. Makar -- is
16 that how you pronounce it?

17 A. Yes.

18 Q. -- and yourself. Dr. Makar was a resident?

19 A. Correct.

20 Q. And what is the usual procedure for a resident
21 seeing a patient and being supervised by a
22 physician such as yourself?

23 A. So they see the patient and they formulate their
24 opinions and then they come and talk to the
25 supervisor and present the case and their ideas

14

1 and thoughts about that, and then I go back with
2 them and talk with them and the patient and so --
3 Q. All right. And how --
4 A. -- and I either agree with them or don't agree
5 with them, but.

6 Q. Okay. So in the exhibit before you, there's a
7 note, supervisory note on the second page?

8 A. Yeah, correct.

9 Q. And it says that you saw is Miss Naambwe with
10 Dr. Makar for supervisory purposes and you agree
11 with her findings and conclusions?

12 A. Correct.

13 Q. And how long, approximately, do you spend with
14 the resident and the patient together before
15 writing this supervisory note?

16 A. Meaning total with talking to the resident and
17 then --

18 Q. Talking -- Well, let's say with the patient.
19 What is the total amount of time?

20 A. That would be variable, you know, from probably
21 five minutes to 15 minutes, something like that.

22 Q. Okay. So it's the resident that really works all
23 this up?

24 A. Correct, yes.

25 Q. And you look over it and make sure that you agree

15

1 with the conclusions?

2 A. Correct.

3 Q. All right. And the second, the next exhibit
4 there, Miss Naambwe saw Dr. Gaines and
5 Dr. Bhatara I think that should have the numbers
6 19 through 21 at the bottom?

7 A. 19 through 21, okay.

8 Q. Do you have anything with 19 through 21 at the
9 bottom?

10 A. I don't think so, no. I don't think I have one
11 with Dr. Gaines, basically. These are all
12 Dr. Berney's, these three.

13 Q. Okay. These are duplicates.

14 Let's look at the one. Can you tell me the
15 date of service on that?

16 A. That is 1-19-2018.

17 Q. And Dr. Berney and Dr. Bharata saw the patient?

18 A. Correct.

19 Q. And you had no involvement in that visit; is that
20 correct?

21 A. Correct.

22 Q. And I'm handing you this exhibit. Can you tell
23 me what date of service that report reflects?

24 A. 4-24-2018.

25 Q. Okay. And did you see the patient at that time

16

1 with Dr. Berney?

2 A. I did.

3 Q. Would it have been Dr. Berney who wrote up this
4 report basically?

5 A. Yes.

6 Q. Okay. Were your notes made just in the standard
7 ordinary course of your medical practice, your
8 supervisory notes?

9 A. Yes.

10 Q. And is it the practice for all physicians in this
11 group to write up their reports of their
12 encounters with their patients?

13 A. Yes.

14 Q. Typically how long after the appointment or
15 session are the notes written up?

16 A. Mine are usually written on the same day as the
17 service.

18 Q. Do you know about the residents?

19 A. Varies. You know, they can -- most of the time
20 it would be the date of service but sometimes it
21 may be four or five days later, week later, I
22 mean.

23 Q. Is there a rule about that?

24 A. Not an exact rule, but, I mean, you can get in
25 trouble if you're late with all your reports.

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1 Q. Okay. And how are the reports stored? Are they
2 stored electronically?

3 A. Yes.

4 Q. Are they in hard copy anywhere?

5 A. No. Unless you copy.

6 Q. Unless you print it out?

7 A. Yeah, right.

8 Q. Do you have access to reports of other health
9 care providers within the Avera system about
10 Miss Naambwe?

11 A. Yes.

12 Q. And, likewise, would, for instance, Miss Olson
13 who is --

14 A. Uh-huh.

15 Q. -- a physician's assistant who saw Miss Naambwe,
16 would she have access to all of the reports about
17 Miss Naambwe that are in the Avera system?

18 A. Yes.

19 Q. Do you recall if you reviewed any of
20 Miss Naambwe's records before meeting with her
21 for the first time?

22 A. No, I don't remember. I don't recall.

23 Q. Do you know how it was that Miss Naambwe came to
24 the University Psychiatry Group?

25 A. I believe she was referred from the primary care

19

1 Q. All right. Well, we're really here today because
2 I want to ask about the diagnoses given to
3 Miss Naambwe by this practice --

4 A. Uh-huh.

5 Q. -- including yourself and Dr. Makar and
6 Dr. Berney. Would it be accurate that the
7 resident would come to a conclusion about a
8 diagnosis and a differential diagnosis and run
9 that by you?

10 A. Correct.

11 Q. All right. In this case, we have the social
12 history on the first report says: The patient
13 came from the Congo in 2004 and has a history of
14 physical abuse at a refugee camp and this is why
15 she's sensitive to people touching her skin. She
16 endorses nightmares and flashbacks.

17 Is this social history significant to the
18 diagnoses that are in here?

19 A. I believe so.

20 Q. In what way?

21 A. Well, I mean, because of past traumatic events
22 are usually not completely forgotten. They're
23 usually -- and they usually influence people's
24 behavior and symptoms, you know, for a long, long
25 period of time.

18

1 people to us for assistance with some symptoms
2 she was having, you know.

3 Q. Do you recall speaking to Kalee Olson about
4 Miss Naambwe?

5 A. No.

6 Q. All right. So I want to take a look at the first
7 visit where you and Dr. Makar saw Miss Naambwe.
8 It appears that a history of the patient was
9 taken. Is that standard practice?

10 A. Yes, uh-huh.

11 Q. And it would have been Dr. Makar who took that
12 history?

13 A. Correct.

14 Q. Okay. Do you know if the patient was given any
15 sort of physical exam?

16 A. No, not that I'm aware of, although they do do --
17 usually do a portion of a neurological exam, you
18 know, at each visit.

19 Q. What portion is that?

20 A. Well, musculoskeletal exam, examination of the
21 cranial nerves with specific emphasis on a bunch
22 of neurological symptoms that are common to
23 psychiatric medication, you know, drug-induced
24 symptoms, so we're looking specifically for those
25 things.

20

1 Q. Would that -- Well, let's just say, there's two
2 diagnoses listed in the assessment section here.
3 One is major depressive disorder recurrent severe
4 with psychotic features and the other is PTSD.

5 A. Correct.

6 Q. The history of what happened in the Congo, is it
7 relevant to both of those diagnoses?

8 A. It could be for certain -- for the posttraumatic
9 stress one, although most people who have that
10 have depression, so.

11 Q. They're comorbid, usually?

12 A. Yeah, usually.

13 Q. All right. Can you tell me what information in
14 this report supports the diagnosis of PTSD?

15 A. Just memories, flashbacks, hyperarousal, kind of
16 sort of a vigilance, and then reactivity to
17 environmental stimulus that reminds the patient
18 of the past, basically.

19 Q. When you say "hyperarousal", what do you mean?

20 A. Easily startled, anxious, you know.

21 Q. Easily irritated?

22 A. Can be. Depends on the situation. Sometimes
23 it's more just fears of, you know....

24 Q. And when you say "reactivity to environmental
25 stimulus", what are you referring to?

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1 A. Something that reminds them in some fashion of
2 what happened to them before.
3 Q. Okay.
4 A. They overreact to those kind of things.
5 Q. So the history of the illness set forth in this
6 report says the patient says she saw people
7 following her that were not there. She says she
8 saw herself having a gun and shooting them. The
9 patient has been afraid in the parking lot.
10 Whenever she sees people, she's paranoid that
11 they might figure out her address. Thus, she is
12 switching streets on her way home so that nobody
13 can find out what her address is. Sometimes
14 she's afraid in her room because people might
15 sneak through the windows. She says she's having
16 a lot of issues with male coworkers. She says
17 she is afraid of people touching her skin and she
18 gets paranoid that the people at work have a
19 knife or a gun. And she has suicidal ideations.

20 Can you tell me how these symptoms support
21 the diagnosis of major depressive disorder and
22 PTSD?

23 A. Well, I mean, those are like your paranoid
24 symptoms which can be and often are a part of
25 posttraumatic stress symptoms. And you can

22

1 get -- also you can get psychotic symptoms in
2 association with depression. So you might get a
3 difference of opinion as to what the cause of
4 them is.

5 I believe one of the residents gave a
6 separate diagnosis for the psychotic symptoms as
7 unspecified psychosis later on, you know, so
8 you -- that's more of an uncertainty diagnosis.
9 If you weren't sure, if you thought it was pretty
10 directly linked into posttraumatic stress, then
11 you would give it that diagnosis.

12 Q. Well, there's several differential diagnoses --
13 A. Yeah.

14 Q. -- including mixed personality disorder, panic
15 disorder, paranoid personality disorder,
16 delusional disorder. Do you know if, in fact,
17 Miss Naambwe was actually diagnosed with any of
18 these?

19 A. I don't believe so, no. You know, a lot of
20 delusional disorder, no, most of those not
21 anyway.

22 Q. I'm sorry?

23 A. I say most of those no.

24 Q. Okay. I believe there was a new diagnosis in the
25 last report that you produced but we don't have

23

1 that, that's getting copied, so we'll go back to
2 that.

3 What is major depressive disorder?
4 A. It's just -- it's depression that's generally has
5 defined onset, may or may not have a clear stress
6 precipitating the depression but the symptoms are
7 severe and present most of the time for a
8 definite --

9 Q. And you -- I'm sorry, go ahead.

10 A. It's just a certain length of time they're
11 supposed to be present, yeah.

12 Q. All right. And the diagnosis here is major
13 depressive disorder recurrent severe with
14 psychotic features. And what does "recurrent"
15 mean?

16 A. It means there's a prior episode of depression.

17 Q. And what are the criteria for a major depressive
18 disorder in terms of how many episodes and the
19 length of the episodes of depression?

20 A. For it to be called recurrent, you have to have
21 two episodes of it that were judged to be
22 major -- a major depressive episode, because you
23 can have a major depressive episode that isn't
24 recurrent as a single episode.

25 Q. So when you say -- Does recurrent, then, imply

24

1 that there are certain periods of time when the
2 patient is not suffering from any sort of
3 depression?

4 A. Yeah. There would be intervals where there
5 wouldn't be depressive symptoms.

6 Q. And --

7 A. Although you can have comorbid things, so you
8 could have posttraumatic stress symptoms that are
9 continuous and episodes of depression on top of
10 that.

11 Q. It's hard to tease them apart, then, isn't it?

12 A. Yes, very much so.

13 Q. When you say psychotic features, what do you
14 mean?

15 A. That means having delusions or false beliefs or
16 hallucinations or bizarre or unusual behavior, I
17 guess, could be psychotic features.

18 Q. All right. And what in this report substantiated
19 or substantiates the diagnosis of major
20 depressive disorder with psychotic features?

21 A. Just symptoms of major depression and
22 accompanying, you know, delusional and
23 hallucinatory symptoms.

24 Q. So a patient comes in with delusional and
25 hallucinatory symptoms. How as a physician do

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1 you determine what is accurate about what the
2 patient is telling you versus what is not
3 accurate in those circumstances?
4 A. You mean -- well, usually try to get as much
5 history from collateral resources as possible.
6 Sometimes they're the records of other
7 physicians, but mostly it's family members or
8 significant others that we get the history from.
9 Could be, you know, jail records or whatever, you
10 know.

11 Q. With respect to Miss Naambwe, did you speak to
12 anyone from her family about her symptoms?

13 A. I believe, yeah, on several occasions there was
14 another person present, but.

15 Q. And who was that?

16 A. Well, I don't remember the name of the person
17 exactly, but.

18 Q. It was a relative?

19 A. Yeah.

20 Q. And did you -- did you yourself speak to this
21 relative?

22 A. Well, briefly. Mostly the person was in the room
23 when they were describing what the symptoms were
24 and the case was, and there was some occasional
25 references for confirming information but there's

26

1 language differences so a lot of it was probably
2 what was being -- trying to figure out what was
3 being said as much as....

4 Q. I see. Was this person Miss Naambwe's son?

5 A. You know, I don't remember, to tell you the
6 truth.

7 Q. That's all right.

8 A. And --

9 Q. Go ahead.

10 A. -- I would have to look at the records to see who
11 it is, yeah.

12 Q. Okay. You -- you did review these records before
13 you came here today?

14 A. To some extent. Not extensively, though.

15 Q. Okay. Did you or anyone in the practice speak to
16 anyone at Miss Naambwe's place of employment?

17 A. No.

18 Q. Did you review any files from her employment?

19 A. No.

20 Q. Did you review files from other medical
21 providers?

22 A. Yes.

23 Q. Which ones?

24 A. The family practice people.

25 Q. And that's --

27

1 A. Dr. Olson primarily, you know, but there was
2 Dr. Jensen.

3 Q. Dr. Jensen?

4 A. Yeah. I believe that's a therapist from family
5 practice.

6 Q. And what was the date of the report that
7 Dr. Jensen wrote that you might have reviewed?

8 A. 3-20-17.

9 Q. 3-20-17. Did you review any reports of emergency
10 room visits or notes?

11 A. No, I don't think so.

12 Q. All right. There's -- on the first page of the
13 document that describes the first visit, there's
14 a reference on the bottom LSS Clinic AMB report,
15 bottom right. Do you see that?

16 A. On the -- the visit of Dr. who and what date?

17 Q. If you just look at the bottom right and there's
18 a reference to what looks like another report,
19 clinic -- or is this your report? I didn't know
20 if that was something different or not.

21 A. You mean of this talking about a report from LSS,
22 that's Lutheran Social Services --

23 Q. Yeah.

24 A. -- counseling agency.

25 Q. It is talking about another report?

28

1 A. Well, if it says LSS, that's what that would be,
2 I believe.

3 Q. Okay. Do you remember what information you
4 received from that report?

5 A. No.

6 Q. All right. So psychotic feature denotes a break
7 from reality; is that correct?

8 A. Correct.

9 Q. And typically how long do they last in a
10 situation like this?

11 A. Well, hard to say how long it would last, you
12 know.

13 Q. Did you -- do you have a sense for how long
14 Miss Naambwe's psychotic feature would last?

15 A. No, not really. It's -- because you can have the
16 onset of more serious illness, you know, such as
17 schizophrenia can present for the first time.

18 You know, sometimes it presents right and then it
19 can continue indefinitely.

20 Q. Yeah. I did notice that on the last report which
21 I'll have -- which is part of the group of papers
22 that you produced, there's a differential
23 diagnosis of schizophrenia.

24 A. Uh-huh.

25 Q. Do you know if that diagnosis has been confirmed?

29

- 1 A. I don't believe so.
2 Q. So with Miss Naambwe, you had her son with her at
3 one visit so you could corroborate some of the
4 symptoms she's describing, correct?
5 A. Right.
6 Q. But outside of that, you don't have any
7 information about her interactions with others;
8 is that -- is that accurate?
9 A. Other than what she's reported to other people.
10 Q. Okay. So when Miss Naambwe comes in and says
11 something like she's being repeatedly sexually
12 assaulted at work and her supervisor refuses to
13 do anything about it, is that something that you
14 take at face value? Do you believe that
15 statement?
16 A. We try to get as much information about what
17 actually happened as we can, you know, rather
18 than take an abstract statement like that, so.
19 Q. Do you remember what information Miss Naambwe
20 gave you about being sexually assaulted at work?
21 A. I was -- I can remember actually trying to figure
22 that out and it was difficult to do so at the
23 time.
24 Q. Why was it difficult, language barrier?
25 A. Partially, yeah. And --

31

- 1 A. No.
2 Q. Would Miss -- the fact that Miss Naambwe has PTSD
3 stemming from her experience in the Congo, might
4 that influence her perception of events in the
5 workplace?
6 A. Yes.
7 Q. Might that cause her to misperceive --
8 A. Yes.
9 Q. -- actions?
10 A. Uh-huh.
11 Q. Miss Naambwe's had several clashes with workers,
12 with coworkers and supervisors and that's led to
13 what -- to the lawsuit today which is a
14 discrimination lawsuit, race discrimination and
15 retaliation. The diagnoses that she has been
16 given, would they -- would these conditions tend
17 to make workplace relationships a little more
18 difficult?
19 A. Well, they could, yes.
20 Q. In what way?
21 A. Well, just that she could be on guard, you know,
22 hypervigilant, worried about being mistreated and
23 overreacting to perceived mistreatment, you know.
24 Q. So, for instance, if someone brushed by her and
25 she reported that as a sexual assault, would that

30

- 1 Q. There is a reference in these reports to Miss
2 Naambwe being a poor historian. What do you
3 understand that to mean?
4 A. That means you can't understand the history that
5 she's giving you.
6 Q. And why, because it's confused? Why might you
7 not understand it?
8 A. Well, could be language barrier. Could be the
9 way a person recalls and describes things in the
10 past, you know, so.
11 Q. So you try to get as much information as possible
12 about an incident the patient describes. To
13 really, you know, determine whether it was true
14 or false, you would have to consult other people,
15 for instance, the people she talks about in the
16 workplace. You did not do that?
17 A. No.
18 Q. Throughout these reports, there seems to be a
19 theme of Miss Naambwe reporting improper sexual
20 activity at work, somebody rubbing up against
21 her, somebody trying to touch her vaginal area,
22 somebody elbowing her. Does this -- did you
23 corroborate any of those statements?
24 A. From her -- like, her work place, you mean?
25 Q. Yeah.

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- 1 be consistent with PTSD syndrome?
2 A. Could be, yes.
3 Q. What -- Have you formed a belief about Miss
4 Naambwe's reports that coworkers are trying to
5 kill her?
6 A. I didn't assume that that was true at the time,
7 no.
8 Q. That's part of her psychotic symptoms?
9 A. Yeah. Her paranoid thinking, I would say, yeah.
10 Q. Are you expressing any opinion with regard to
11 Miss Naambwe as to the cause of her PTSD and
12 major depressive disorder?
13 A. Well, no. I mean, I don't have enough detail
14 to -- about history in the Congo to know for
15 sure.
16 Q. So you say you don't have enough detail to know
17 for sure the cause of her illnesses --
18 A. Yeah.
19 Q. -- is that accurate?
20 A. Yes.
21 Q. Okay. So you're not offering an opinion to --
22 that says with a reasonable degree of medical
23 certainty that there was a particular cause for
24 any of these illnesses. Is that accurate?
25 A. I don't know. I think more accurate would be I

William T. Fuller
September 24, 2018

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1 don't have enough detail about events that
2 happened to her to know how much of it is
3 directly related to traumatic incidents and how
4 much is kind of an elaboration or kind of a
5 paranoid thinking process or hallucinatory
6 process so where the line changes there.

7 Q. Okay.

8 A. I don't think I have enough information to say
9 for sure on that, although it does appear that a
10 lot of things that she was thinking were not
11 possible, so it does seem like those were
12 psychotic symptoms, but exactly what did happen
13 and didn't happen is always really hard to
14 figure, you know.

15 Q. So -- so but you're not -- just to confirm,
16 you're not going to testify in this case about
17 any opinion about the cause of her illnesses. Is
18 that accurate?

19 A. There's -- there's really only one thing in these
20 records that makes you wonder and that's several
21 references why these other clinicians that were
22 seeing her said that someone was transferred or
23 left the immediate workplace that she was in and
24 that her symptoms dramatically improved when that
25 happened. Several clinicians said that so it

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1 leads me to believe that somebody in her
2 workplace was doing something, either that she
3 was overreacting to it or else actually did
4 something that she was reacting like most people
5 would and that person leaving really seemed
6 to change her symptoms. So I believe there was
7 either perceived or a real thing with another
8 person.

9 Q. But you don't know if it was a perceived thing or
10 a real thing?

11 A. No, I don't. I mean, she said a bunch of stuff
12 about it, you know, like she went to her
13 superiors and they wouldn't listen to her and
14 this person was a friend of the supervisor and a
15 bunch of stuff like that that would make you
16 really wonder but, no, I don't have enough
17 information to know for sure.

18 Q. All right. And, in fact, her paranoid symptoms
19 could have preceded these events with the
20 coworker, correct?

21 A. Sure.

22 Q. And had influenced her perception of what they
23 did?

24 A. Yeah, could have been like he didn't do anything,
25 she just imagined he was doing things. But,

35

1 either way, she seemed to respond real positively
2 when he was out of the picture.
3 Q. She reported that he had been fired for sexual
4 assault. Do you know if that was true or not?
5 A. I do not. I would think probably not but maybe,
6 you know. I mean, I didn't think that was
7 probably true, but.

8 Q. Okay. And the report that she was doing better
9 came roughly in 20 -- Well, let me get the date
10 right. Well, strike that. After she reported
11 feeling better because this individual was gone,
12 there were additional relapses into --

13 A. Continued symptoms.

14 Q. Continue symptoms?

15 A. Yeah.

16 Q. All right. And have those continued as far as
17 you know through the recent consultation this
18 practice has had with her?

19 A. Yes.

20 Q. What do you recall in these reports about
21 Miss Naambwe's compliance with her medication
22 regime?

23 A. I think she's pretty compliant, other than one of
24 her medications was very expensive so she didn't
25 want to take it. The Lurasidone or Latuda,

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1 they're both antipsychotic --

2 COURT REPORTER: I'm sorry, say those again.
3 THE WITNESS: Lurasidone,
4 L-u-r-a-z-i-d-o-n-e [sic].

5 COURT REPORTER: Thank you.

6 BY MS. CALEM:

7 Q. Well, there are numerous references in these
8 reports to noncompliance with medication. For
9 instance, in the last -- can you look at the
10 April 2018 visit? Do you have that document in
11 front of you?

12 A. April -- yep, I do.

13 Q. April 2018.

14 A. Right.

15 Q. Okay. And there's a reference in there to her
16 using Seroquel but only every few days.

17 A. Uh-huh.

18 Q. What symptoms does the Seroquel treat?

19 A. It's an antipsychotic, but it also has a lot of
20 antianxiety symptoms frequently used for people
21 that are having trouble sleeping.

22 Q. Okay. On the second page of that report,
23 Miss Naambwe says when she is taking the
24 Seroquel, she's not angry or yelling and it helps
25 with her concentration, she does better at work.

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1 A. Uh-huh.
 2 Q. And, however, it does say she's only taking it
 3 every third day and then she starts having
 4 problems.
 5 A. (Indicating).
 6 Q. Would this failure to comply consistently with
 7 the Seroquel prescription, could that lead to
 8 greater incidents of workplace conflict?
 9 A. Well, yeah, she could have more symptoms, yeah,
 10 for that.
 11 Q. And if she was noncompliant in general with
 12 medication designed to treat her mental
 13 illnesses, could that have an adverse effect on
 14 her interactions with people in the workplace?
 15 A. It could.
 16 Q. Do you have any -- when you say that you believe
 17 she was mostly compliant, on what do you base
 18 that?
 19 A. Well, I mean, I think she was -- had tried to
 20 take all of the medications that they were
 21 prescribed. It's not terrifically unusual for
 22 psychotic patients to not take their medications
 23 all the time, especially when they're first
 24 diagnosed. It's actually true of all people with
 25 all medications but, so.

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1 Q. His diagnosis was psychotic disorder unspecified.
 2 Do you believe that the patient's symptoms
 3 support that diagnosis?
 4 A. Well, as I say before, that's a non -- a sort of
 5 like a transitional diagnosis usually or else the
 6 symptoms are unusual, they don't fit exactly any
 7 of the standard psychotic diagnosis. So, no, it
 8 doesn't surprise me that someone would give her
 9 that diagnosis.
 10 Q. All right. On the first page of the -- the
 11 September report, it says patient was last seen
 12 by Dr. Berney on June 22, 2018. At that time
 13 Latuda was discontinued due to cost and she was
 14 started on Risperdal one milligram twice daily.
 15 She was continued on Zoloft 100 milligrams and
 16 Prazosin two milligrams. Can you tell me what
 17 Risperdal is designed to treat?
 18 A. An antipsychotic medication.
 19 Q. And Zoloft?
 20 A. Antidepressant.
 21 Q. And Prazosin?
 22 A. It's for -- generally for nightmares.
 23 Q. All right. Patient indicates that she's been
 24 taking the Risperdal once in the evening but does
 25 not take the medications daily. Would that

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1 Q. Do you know, are you familiar with the fact that
 2 Miss Naambwe has high blood pressure?
 3 A. Yes.
 4 Q. And if she is not compliant with her blood
 5 pressure medication, might that have an effect on
 6 her mental and emotional well-being?
 7 A. Might. Headaches mainly is, I think --
 8 Q. Headache?
 9 A. -- was the symptoms that she had.
 10 Q. Okay. So if we look at -- I'm trying to find the
 11 date of this report. Can you tell me the date of
 12 service on this, of this visit?
 13 A. That was September 13th.
 14 Q. Of what year?
 15 A. '18.
 16 Q. 2018, all right.
 17 So that's in the package that you -- that
 18 you received, Stephanie.
 19 This is a report that we had not had
 20 previously. Dr. Nuss, is that how you pronounce
 21 it --
 22 A. (Indicating).
 23 Q. -- was the attending? And his -- is Dr. Nuss a
 24 man or a woman?
 25 A. A man.

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1 indicate noncompliance?
 2 A. Well, yeah, sure.
 3 Q. At this point in time in September of 2018,
 4 Miss Naambwe is still reporting paranoid
 5 symptoms, someone will kill her, someone is
 6 following her in a car, someone will bomb her
 7 house, and the food in the cafeteria is being
 8 poisoned, her food. Are you familiar with that
 9 statement?
 10 A. No, I didn't recall that.
 11 Q. Would a belief that the food in the cafeteria,
 12 her food in the cafeteria is being poisoned,
 13 would that be a symptom of a psychotic feature of
 14 her depression?
 15 A. Well, psychotic features of something, right.
 16 Q. If Miss Naambwe has reported at times that she
 17 loses track of time, kind of blanks out for maybe
 18 a minute or two, doesn't know where she is, is
 19 this a symptom of any of the illnesses with which
 20 she has been diagnosed?
 21 A. Predominantly posttraumatic stress disorder.
 22 Q. And how does that --
 23 A. I mean, you can have --
 24 Q. -- that --
 25 A. -- similar things with depression, yeah.

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- 1 Q. Okay. And how do you define posttraumatic stress
2 disorder?
3 A. It's a syndrome that follows an identifiable
4 stress that would cause anybody to have symptoms,
5 basically, and the symptoms persist after the
6 event and they're, you know, flashbacks,
7 nightmares, hypervigilance, reactivity to
8 stimulus, general withdrawal, emotional lability.
9 Q. Can the symptoms sometimes emerge years after the
10 incident happened?
11 A. Sometimes, yeah.
12 Q. Ms. Naambwe's testimony in her deposition was
13 that she -- her symptoms were entirely due to
14 this mistreatment at work, had nothing to do with
15 her experiences in the Congo. What do you think
16 about that statement?
17 A. Well, I don't know. You know, I mean, obviously
18 there's -- there's some things happening that are
19 not only related to the workplace environment,
20 you know, so.
21 Q. So you would not believe that that was an
22 accurate statement, would you?
23 A. Well, I need a lot more information. It's
24 possible that nothing happened to her in the
25 Congo, you know, and I just don't know it, right,

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- 1 so.
2 Q. Have you -- Well, in your views, could
3 Miss Naambwe benefit from psychotherapy?
4 A. Probably, if she had someone that could speak her
5 language.
6 Q. Have -- has she ever expressed an interest in it,
7 to your knowledge?
8 A. No, not to my knowledge.
9 Q. Have you suggested it to her?
10 A. No.
11 Q. On these reports, there's a section that talks
12 about insight. What does the word "insight" mean
13 within the context of a report like that?
14 A. Understanding of your illness, basically.
15 Q. There are several references to Miss Naambwe
16 having limited insight. Would you agree with
17 that?
18 A. Well, I don't know for sure on that.
19 Q. Is there a test or an -- a test to measure
20 insight?
21 A. Mainly just talking to the person or interviewing
22 them, almost always in cases like this. So
23 there's different kinds of insight, right,
24 knowing something's wrong with you, knowing that
25 the doctor might help you, you know,

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- 1 understanding that perhaps some behaviors you
2 have are subtly influencing someone else and that
3 reaction to you may be what you're feeling, you
4 know, as well as, like, a high level of insight.
5 So there's -- there's a lot of different levels
6 of insight. So generally with somebody who's
7 psychotic, you're talking about do they know that
8 they have psychotic symptoms that they may
9 benefit from, you know, that they should take
10 their medications to help those symptoms. That's
11 usually the main thing, but there are people who
12 know something's wrong, they just don't exactly
13 believe the doctor's got it right, you know.
14 Q. So there's sort of a continuum with insight?
15 A. Yes, right.
16 Q. I mean, some people might fully understand that
17 they have a mental illness and there's some
18 things that aren't there and other people would
19 be in complete denial, those would be the two
20 ends of the spectrum?
21 A. Yeah. Yes.
22 Q. And if -- when this report says Miss Naambwe's
23 insight was limited, what do you think it means?
24 A. I think it means that she doesn't understand some
25 of the things that I don't understand, like what

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- 1 is causing her symptoms, where they're coming
2 from, what's real, what isn't real, you know,
3 whether or not people might actually be following
4 her or not would be the kind of area I would say
5 where her insight is limited or, like, this
6 person at work was following her around outside
7 of the workplace or, you know, that kind of
8 insight.
9 Q. I just want to go back to this first report. In
10 one of these reports, Miss Naambwe denies being
11 depressed despite her diagnosis. Does that
12 reflect a lack of insight about her condition?
13 A. I would think so, yes.
14 Q. And if she -- in one of the reports, she reported
15 that she believed people were poisoning her food
16 in the cafeteria and said to the physician who
17 she was speaking to, well, you don't know for
18 sure that's not true, does that reflect lack of
19 insight about her condition?
20 A. I would say so, yes.
21 MS. CALEM: Let's go off the record for a
22 minute.
23 (A recess was taken at this time.)
24 MS. CALEM: Back on the record.
25 Are you able to render an opinion about

45

1 whether or not Miss Naambwe was being truthful in
2 reporting her symptoms, for instance,
3 sleeplessness, crying, all of that?

4 A. No. I don't have any -- any reason to think she
5 wasn't being truthful.

6 Q. Well, as a physician, how do you deal with that,
7 then? You just sort of take the patients at
8 their word?

9 A. You generally do.

10 Q. You mentioned that Miss Naambwe's son was at some
11 of these appointments. Do you know if he
12 corroborated any of the symptoms?

13 A. Yeah, to some degree, yeah.

14 Q. What symptoms did he corroborate?

15 A. I don't know for sure. I just know he was there.

16 Q. Okay. But you don't know for certain that he
17 corroborated them?

18 A. No. I wouldn't be able to testify one way or the
19 other on that.

20 Q. So you're sort of making at an assumption that,
21 yes, he might have corroborated them but you
22 don't know for certain, right?

23 A. Right.

24 Q. Okay. And do you believe that given the history,
25 the resident had enough information to diagnose

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1 Miss Naambwe with PTSD and major depressive
2 disorder?

3 A. I don't know for sure actually, but -- but I
4 would think so, yes.

5 Q. Well, what are the criteria for PTSD? I mean
6 there's a DSM definition for it; is there not?

7 A. Sure.

8 Q. What does the criteria usually, like, list? Two
9 out of these five, three out of these?

10 A. Yeah.

11 Q. Do you know what the criteria are for PTSD --

12 A. Well --

13 Q. -- without looking at the DSM?

14 A. Not in detail that way but, you know, the general
15 idea and the symptoms that are present, you know,
16 so.

17 Q. Okay. So but in terms of Ms. Naambwe's symptoms,
18 you can't say how many of the PTSD symptoms that
19 are in DSM she actually had for what period of
20 time; is that accurate?

21 A. Well, I think we could say a lot of the symptoms
22 that she did have. We don't -- what we don't
23 know is the nature of the original, you know,
24 traumatic event.

25 Q. Well, she reported sexual abuse. Would that be a

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1 traumatic event?

2 A. Yeah, sure, but we don't know exactly what
3 happened. And so if it's a reliving or
4 recreation of a past experience and you have
5 someone with psychotic symptoms, then it's kind
6 of hard to tell what's from posttraumatic stress
7 and what's from maybe something else. So it's
8 unclear in her case and it would be --

9 Q. So it's the -- you're saying that it's not clear
10 what disorder her symptoms result from in all
11 cases?

12 A. Yeah. Well, where -- where the line is drawn, I
13 guess, between.

14 Q. Okay. Does Miss Naambwe show signs of having
15 some sort of personality disorder? It was in the
16 differential diagnosis.

17 A. Yeah. I don't think so, no.

18 Q. And why -- why, then, was it in the differential
19 diagnosis?

20 A. Because it could produce these symptoms.

21 Q. Okay. Would someone with a personality disorder
22 tend to be untruthful in reporting their
23 symptoms?

24 A. Could be, depending upon the personality
25 disorder.

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1 Q. Well, what about mixed personality disorder?

2 A. About which?

3 Q. Wasn't the differential mixed personality
4 disorder?

5 A. Oh, mixed is....

6 Q. What does that mean?

7 A. That means the symptoms were for more than one
8 personality disorder.

9 Q. Can you define what a personality disorder is?

10 A. Sort of a lifelong pattern of behavior that's
11 maladaptive.

12 Q. Maladaptive coping?

13 A. Well, it could be a lot of different -- you know,
14 like, there's obsessive/compulsive personality
15 which is a pattern of being overly detailed or
16 working too much and intolerant of other people's
17 mistakes and errors and so forth and so on. And
18 then it's maladaptive in a number of different
19 ways, but it's not going to produce somebody
20 who's not going to tell the truth, you know.

21 Q. Okay.

22 A. And there's antisocial personality which is a
23 habitual criminal, of course, they're always
24 untruthful, you know.

25 Q. And what about, is there such a thing as a

	49		51
1	paranoid personality disorder?	1	that the situation in the Congo was what created
2	A. There is, yeah.	2	the PTSD symptoms?
3	Q. And can you explain how that manifests?	3	A. Right.
4	A. Usually just kind of a very widespread distrust	4	Q. Okay. Are you saying that to a reasonable degree
5	and friction with others based upon multiple	5	of medical certainty or just a more likely than
6	different kinds of distrust and so those people	6	not, you just don't know?
7	are continuously getting conflict, you know, so	7	A. I would say more likely than not, you know.
8	they're oftentimes in lawsuits, paranoid	8	Q. All right. What about the depression with the
9	personality disorders are.	9	psychotic features, can you pin down a cause of
10	Q. Well, so is it possible, then, that that	10	that?
11	diagnosis also applies to Miss Naambwe, because	11	A. Well, not usually. I mean, there's almost always
12	based on what you just said, it's exactly what's	12	biological factors involved in that particular
13	happened?	13	disorder and that would be a need to have, like,
14	MS. POCHOP: Well --	14	a pretty good history of, like, her family tree
15	A. Yeah, I don't think that's what she has, no.	15	and we would have to do some kind of translating
16	Q. Why not?	16	the cross cultures as to what depression is and
17	A. Well, because I just don't think -- well, for one	17	how that would be reported. And, you know, it
18	thing, you don't get psychotic symptoms, you	18	would be difficult basically to know everything,
19	know.	19	but there always are biological aspects to it.
20	Q. With the personality disorder?	20	Q. You don't have that information for Miss Naambwe,
21	A. Right.	21	do you?
22	Q. But could the personality disorder be comorbid	22	A. No.
23	with something that gave you psychotic symptoms?	23	Q. Okay. So can you state with a degree of --
24	A. Sure.	24	reasonable degree of medical certainty that she
25	Q. Okay. So in terms of the symptoms she came into	25	has major depressive disorder with psychotic
	50		52
1	the clinic reporting, I just sort of want to nail	1	features?
2	down if you have any -- if you're giving any	2	A. Well, I think that we can say that she has major
3	opinion or making any statement about the cause	3	depression. Whether the psychotic features are
4	of them. You said you really can't determine	4	related to the depression or not is probably open
5	what happened at work and you can't determine	5	to question.
6	exactly what happened in the Congo. You talked	6	Q. Well, what else would they be related to?
7	about her feeling better when some coworker was	7	A. What could they be related to? They could be
8	supposedly fired which led you --	8	related -- be schizophrenia, there's a lot of
9	A. No, I didn't say fired. It says it in the	9	people that are under stress, and when they have
10	record, yeah.	10	posttraumatic stress disorder will get transient
11	Q. Okay. That he supposedly -- that he went away so	11	psychotic symptoms, you know, so.
12	she was feeling better.	12	Q. All right. So Miss Naambwe experienced an
13	A. Yeah.	13	incident in the workplace where a coworker made
14	Q. So I guess I'm trying to figure out, what is the	14	racist statements to her. Are you expressing any
15	traumatic event? What are you saying is the	15	opinion as to whether or not that might have
16	traumatic event that has caused her PTSD?	16	caused any of her symptoms?
17	A. Well, I think the assumption is that before she	17	A. I do not know.
18	got to the United States, that she was mistreated	18	Q. You could not say, could you?
19	probably physically, likely sexually, and, you	19	A. No.
20	know, who knows what in terms of, you know, like,	20	Q. Would a person with PTSD and major depressive
21	mental abuse or whatever and that that would	21	disorder have a harder time getting over
22	predispose her to, you know, reacting to a lot of	22	something that bothered them in the workplace
23	different situations with anxiety and depression	23	than people without those disorders?
24	and....	24	A. Yes.
25	Q. So you believe that it's more likely than not	25	Q. Might they then -- Well, strike that. Do you

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1 intend to speak to any of Miss Naambwe's family
2 members about her condition?

3 A. In the future?

4 Q. Yeah.

5 A. Well, it kind of depends, you know. Like, it may
6 be that I will not, in the ordinary series of
7 events, have anything to do with the supervision
8 of the current resident that's treating her.

9 Q. So that means you don't know if you will?

10 A. No, I don't. I don't know if -- but pretty
11 likely that she is being seen -- or was seeing a
12 resident that's mostly not here when I'm here and
13 is supervised by Dr. Nuss so that's most likely
14 what's going to happen.

15 Q. So you don't necessarily anticipate being a part
16 of Ms. Naambwe's treatment in the future?

17 A. Right.

18 Q. Does somebody with the conditions that
19 Miss Naambwe's been diagnosed with tend to have a
20 low self-image or self-esteem?

21 A. Certainly can, yeah.

22 Q. Do you know if that's the case with Miss Naambwe?

23 A. No, I don't know.

24 Q. Miss Naambwe, in an emergency room visit, said
25 that a coworker coerced her into trying to touch

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1 his genitals and then went behind her and stabbed
2 her with something and then an electrical shock
3 went up her back. Would you consider this to be
4 a description -- would you consider this
5 description to be accurate that something like
6 that really happened?

7 A. Unlikely, yeah.

8 Q. If Miss Naambwe told Ms. Olson that she will
9 frequently see people across the room in flashes
10 of light, is that evidence of a psychotic
11 symptom?

12 A. Yeah. That's very unlikely, I guess.

13 Q. When she says a man at work is placing witchcraft
14 spells on her, is that, again, symptomatic of her
15 psychosis?

16 A. Yeah. I mean -- I mean, I think the resident
17 that reported that said they didn't know if that
18 had something to do with cultural beliefs, but.

19 Q. That was Ms. Olson. What does that mean?

20 A. What? That means she doesn't understand the
21 culture which she was raised in.

22 Q. Okay. But in terms of this culture, someone who
23 says that is generally thought to be exhibiting
24 some form of psychosis, correct?

25 A. Correct, yeah.

55

1 Q. So just to -- I keep circling back to this but I
2 just want to be certain of this. You're not
3 saying that a traumatic event at work caused any
4 of these symptoms from Miss Naambwe, are you?

5 A. Well, I don't know -- I don't know for certain.
6 It does appear that some degree of anxiety was
7 present, you know, related to the work situation
8 and that that did get better, you know.

9 Q. Okay. But -- but you don't know the
10 circumstances behind that, correct?

11 A. No.

12 Q. And that getting better did not persist, right?
13 She relapsed into psychotic symptoms, correct?

14 A. I don't know that for sure, either --

15 Q. Well --

16 A. -- I mean, whether the getting better persisted
17 or not.

18 Q. Okay. Well, do you remember the date on which
19 she said she was getting better?

20 A. No. I mean, I could look it up.

21 Q. Well, do you have it in your notes there?

22 A. Do I have it in my -- no, I don't, really.

23 Q. Okay. But assuming that she then relapsed and
24 had further psychotic symptoms, would that tend
25 to indicate that that stressor at work is not

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1 really the cause of her problems?

2 A. Well, certainly not the sole cause of her
3 problems, right, the only cause of her problems.
4 She has other things happening.

5 Q. And her perception of an event at work could have
6 been distorted based on her symptomology,
7 correct?

8 A. Correct.

9 Q. And do you have any idea of what traumatic event
10 may have happened at work?

11 A. Well, she says that -- that people said
12 suggestive things to her and that she was touched
13 in a sexual fashion and other things that
14 happened that seemed like they probably didn't
15 happen is basically the way it sounds to me, so.

16 Q. And I think we discussed this before, but her
17 reports of being touched and being sexually
18 abused, could that -- those be influenced by her
19 oversensitivity to touch based on what happened
20 to her in the Congo?

21 A. Could be, or could be totally psychotic and it
22 didn't happen at all, you know. I mean, there's
23 no way to know. I mean....

24 Q. Early in her time at Smithfield, Miss Naambwe had
25 a conflict with a coworker which escalated to the

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1 point where they had to be separated into
2 different departments and then Miss Naambwe
3 claimed that that coworker was trying to run her
4 over with her car.

5 A. Uh-huh.

6 Q. What's your reaction to that report? How does it
7 connect with the symptoms of the diagnoses?

8 A. I mean, I don't know. I mean, I don't have any
9 good answer.

10 Q. You don't know if that's an accurate report or
11 not?

12 A. Well, yeah, I don't know anything about it.

13 Q. Okay. Could it have been a symptom of her
14 paranoia?

15 A. Sure, could have been.

16 Q. So, I mean, you know, the reports consistently
17 refer to Miss Naambwe as someone who's a poor
18 historian, whose insight is limited. Does that
19 suggest that many of the incidents she relates
20 are not, in fact, true?

21 A. Not necessarily, but could.

22 Q. It could?

23 A. Yeah.

24 Q. So it's possible that if you went into the
25 workplace and talked to everybody who was

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1 involved in these incidents, you would find out
2 that Ms. Naambwe's version of events did not
3 tally with what they perceived to be real?

4 A. Correct, yeah, could be.

5 Q. If Miss Naambwe acknowledged that the information
6 she gave her doctors about what was happening at
7 work was not accurate, what would that tell you
8 about her level of truthfulness?

9 A. I mean, if she told me the things she told the
10 doctors weren't true?

11 Q. Well, let me go back and explain this. In her --
12 in Miss Naambwe's deposition, I asked her about a
13 report that she gave to her doctor about being
14 repeatedly sexually abused by a man who she'd
15 accused of sexual harassment, and she conceded to
16 me that, in fact, that report that she gave her
17 doctor was not true, he had not repeatedly
18 sexually harassed her. What does that tell you
19 about her level of truthfulness in reporting her
20 symptoms?

21 A. I don't know. What did she say did happen?

22 Q. She said that early in years before, he had
23 pointed at his penis but otherwise had not
24 touched her.

25 A. Years before?

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1 Q. She talked about an individual who in 2014 she
2 believes pointed at his penis. She said he never
3 touched her, never did anything else ever again
4 after that but she told her doctors that she was
5 being repeatedly sexually abused at work. What
6 does that tell you?

7 A. I don't know. That's weird.

8 Q. It's weird. Does it suggest a level -- well, it
9 certainly suggests a poor historian, correct?

10 A. Yeah.

11 Q. And does it suggest a level of untruthfulness?

12 A. Well, I don't know. I mean, it seems unusual,
13 right, in a number of different ways, yeah.

14 Q. Are there people who exaggerate their symptoms
15 when they go to the doctor and talk about them?

16 A. Sure, yeah.

17 Q. And how do you determine if somebody's
18 exaggerating or not?

19 A. You -- The only way is if you have confirming --
20 something that's confirming history one way or
21 another.

22 Q. And in this case, you don't have that, correct?

23 A. No.

24 MS. CALEM: Okay. Let's go off the record.

25 I think I'm done.

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1 (An off-the-record discussion was held.)

2 MS. MARSO: Let's go on the record.

3 THE WITNESS: Yeah. On the record you were
4 saying you didn't have much more to ask, right?

5 MS. CALEM: Right. But you were making a
6 comment.

7 THE WITNESS: Yeah. I was just making an
8 offhand comment.

9 MS. CALEM: Okay. Is it relevant to
10 Miss Naambwe?

11 THE WITNESS: No.

12 MS. CALEM: All right. We're going to go
13 off.

14 (An off-the-record discussion was held.)

15 MS. CALEM: Why don't you go ahead,
16 Stephanie.

17 EXAMINATION BY MS. POCHOP:

18 Q. You haven't personally had a significant amount
19 of contact with Miss Naambwe?

20 A. Not much, no.

21 Q. Okay. The contact you have had has -- you've
22 observed that there's a language barrier for her?

23 A. Correct.

24 Q. How does her language barrier affect your ability
25 to get a history from her?

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1 A. Well, it's hard to get a description of events
2 and understand exactly what she means.
3 Q. Do you have a way of assessing how well she
4 understands what you're relating to her in
5 English?
6 A. Not really, no. I mean, probably need a good
7 translator, you know, in order to be able to
8 understand anything.
9 Q. Have you observed -- do you think that her level
10 of education has -- creates a barrier in terms of
11 her insight and understanding of her condition?
12 A. Probably, yes.
13 Q. And how -- how would that affect her ability to
14 understand her -- have insight into her
15 condition?
16 A. Would make it certainly less -- less ability to
17 communicate about it, for sure.
18 Q. Okay. You mentioned that there's cultural
19 differences that impact the ability to diagnose
20 and treat Miss Naambwe. How does -- how do
21 cultural differences figure into the evaluation
22 and treatment that she's been provided here?
23 A. Well, cultural differences probably make it
24 difficult for the residents or myself or whoever
25 attending to understand completely what she means

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1 A. Yes.
2 Q. What did -- what did -- what was the conclusion
3 reached by the residents that evaluated her in
4 terms of her work environment?
5 A. I think they would -- they all thought that
6 something was happening at work that was causing
7 distress, a lot of distress, and I think most of
8 them would say they don't know exactly what it
9 was that was producing the distress.
10 Q. In your experience as a treating physician, can a
11 hostile work environment exacerbate PTSD
12 symptoms?
13 A. Sure, yes.
14 Q. Can a hostile work environment exacerbate major
15 depressive symptoms?
16 A. Yes.
17 Q. Would -- what kind of advice would you give a
18 person who has PTSD and major depressive symptoms
19 like Sala who reports feeling very stressful and
20 having these incidents at work? What should she
21 do on her day-to-day work life to try to make
22 herself better?
23 MS. CALEM: Objection.
24 A. Well, I mean, you would want, if possible, some
25 kind of an environmental intervention, could be

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1 when she says almost anything, you know.
2 Q. All right. In terms of -- so you have a person
3 that's difficult to communicate with and even
4 just to really, like, literally understand what
5 they're saying?
6 A. Uh-huh.
7 Q. Yes?
8 A. Yes.
9 Q. And can you tell me, then, what is the goal of
10 the treatment that she's received here at Avera?
11 A. Would be to decrease the amount of hallucinatory
12 symptoms that she has, decrease the amount of
13 overt paranoid symptoms that she was -- that she
14 had, and improve her mood and probably reduce the
15 fearfulness, anxiety.
16 Q. In your treatment, do you think that her work
17 environment figures into the symptoms that she is
18 reporting?
19 MS. CALEM: Objection.
20 A. Yeah. I mean, directly I probably can't say.
21 Several of the residents and other doctors did,
22 you know, so.
23 Q. But when you reviewed -- I mean, you reviewed
24 their notes because you were approving your
25 residents' evaluation, right?

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1 like a case manager or a home care worker or some
2 kind of cooperation with the HR department at the
3 work or something like that; you know, something
4 that would -- could get a direct handle on what
5 was going on and if there were any solutions that
6 could happen within her environment that could
7 make things a lot better.
8 Q. Do you know what's been recommended to her in
9 terms of when she believes these incidents have
10 arisen at work, what medical advice has she
11 gotten about how she should deal with them? She
12 supposed to come here and talk to a physician or
13 is she he supposed to talk to somebody at work?
14 What's the protocol --
15 MS. CALEM: Objection.
16 Q. -- recommended for her?
17 A. Yeah. The only person that really directly
18 talked about that was the therapist, you know,
19 said that she should go to HR and she should
20 report this and told her multiple different
21 avenues to take to intervene in the situation but
22 that's the only place. Of course, she's not a
23 physician. She was a therapist who was working
24 with the family practice department.
25 Q. Having reviewed her notes in the process of

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1 providing treatment, do you think that advising
2 Sala to report to HR or follow company protocols
3 is a healthy thing for her to do?

4 MS. CALEM: Objection.

5 A. Yeah. Well, I mean, I think, yeah, ordinarily
6 good advice to be given but I'm not -- Yeah. I
7 don't know what all the issues are here, but.

8 Q. Okay. And in terms of, I see that the last note
9 that you have is September 13th of 2018, and it
10 indicates that therapy is not recommended -- or
11 not indicated at this time. Why would -- I'm
12 looking over here on page 4 under the treatment
13 plan.

14 A. Uh-huh.

15 Q. Why -- why isn't therapy recommended or indicated
16 at this time?

17 A. Well, I think that therapy isn't indicated in,
18 like, a generic term or, like, for the disorder
19 that she has or wouldn't ordinarily help. I
20 think they're meaning the communication barrier
21 is too great --

22 Q. Okay.

23 A. -- to be able to make therapy work.

24 MS. POCHOP: Thank you. I don't have
25 anything further.

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1 MS. CALEM: I just want to follow up on one
2 thing.

3 EXAMINATION BY MS. CALEM:

4 Q. You said that you think the residents would say
5 that something happened at work that was causing
6 her distress?

7 A. Yes.

8 Q. Can you tell me precisely the basis for that
9 statement? You can look through your records if
10 you want. What is it that they said that
11 indicated that?

12 A. Well, just describing what she had told them,
13 basically.

14 Q. So it's based on her reporting, correct?

15 A. Yes, correct.

16 Q. They did not independently corroborate any of
17 this?

18 A. No.

19 Q. Is there a particular report that you're
20 referring to in which there's a reference to
21 something happening at work?

22 A. Well, there's more than one report. And if you
23 want me to, I can go through and pick it out
24 exactly who said what, but there's several people
25 who made references to things happening at work.

1 Q. And based on what she told them?

2 A. Yes.

3 MS. CALEM: Nothing further.

4 MS. POCHOP: I don't have anything further.
5 MS. CALEM: Thank you very much for your
6 time.

7 MS. MARSO: Do you want to read and sign or
8 waive the reading and signing? Do you know what
9 that means?

10 THE WITNESS: Yes.

11 MS. MARSO: I think I want to waive the
12 reading and signing.

13 * * *

14 (Deposition concluded at 6:19 p.m., 9-24-18.)

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1 STATE OF SOUTH DAKOTA) CERTIFICATE
2 COUNTY OF MINNEHAHA)

3 I, Suzanne Brudigan, Court Reporter and
4 Notary Public within and for the State of South
Dakota:

5 DO HEREBY ATTEST that the witness was
6 first duly sworn by me to testify to the truth,
7 the whole truth, and nothing but the truth
relative to the matter under consideration, and
that the foregoing pages 1-67, inclusive, are a
true and correct transcript of my stenotype notes
made during the time of the taking of the
deposition of this witness.

8 I FURTHER ASSERT that I am not an
9 attorney for, nor related to the parties to this
10 action, and that I am in no way interested in the
outcome of this action.

11 In testimony whereof, I have hereunto set
my hand and official seal this 30th day of
September, 2018.

12

13

14

/s/ Suzanne Brudigan

15

Suzanne Brudigan, Notary Public

16

My Commission expires 8-4-20.

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